

Facility Name & ID Number HILLVIEW HEALTH CARE CENTER

0045302 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,827</u>	<u>2,196</u>	<u>2,638</u>	<u>19,661</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,827</u>	<u>2,196</u>	<u>2,638</u>	<u>19,661</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.07%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/ 13 /2001

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/13/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number

of beds certified 69 and days of care provided 1,156

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLVIEW HEALTH CARE CENTER # 0045302 Report Period Beginning: 1/1/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	110,109	8,417	4,326	122,852		122,852	283	123,135			1
2	Food Purchase		86,385		86,385		86,385	(676)	85,709			2
3	Housekeeping	53,713	9,222	6,529	69,464		69,464	1,910	71,374			3
4	Laundry	27,661	8,830	4,354	40,845		40,845	3,003	43,848			4
5	Heat and Other Utilities			55,021	55,021		55,021	(984)	54,037			5
6	Maintenance	29,583	5,246	23,459	58,288		58,288	313	58,601			6
7	Other (specify):*											7
8	TOTAL General Services	221,066	118,100	93,689	432,855		432,855	3,849	436,704			8
	B. Health Care and Programs											
9	Medical Director			4,950	4,950		4,950		4,950			9
10	Nursing and Medical Records	542,396	68,710	5,179	616,285		616,285	(6,050)	610,235			10
10a	Therapy			73,080	73,080		73,080		73,080			10a
11	Activities	18,423	2,028		20,451		20,451		20,451			11
12	Social Services	47,885	20	1,715	49,620		49,620		49,620			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	608,704	70,758	84,924	764,386		764,386	(6,050)	758,336			16
	C. General Administration											
17	Administrative	45,532			45,532		45,532		45,532			17
18	Directors Fees											18
19	Professional Services			121,713	121,713		121,713	(56,666)	65,047			19
20	Dues, Fees, Subscriptions & Promotions			3,139	3,139		3,139	(626)	2,513			20
21	Clerical & General Office Expenses	37,698	6,267	15,332	59,297		59,297	218	59,515			21
22	Employee Benefits & Payroll Taxes			147,056	147,056		147,056	(414)	146,642			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,304	1,304		1,304		1,304			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			20,297	20,297		20,297	111	20,408			26
27	Other (specify):*											27
28	TOTAL General Administration	83,230	6,267	308,841	398,338		398,338	(57,377)	340,961			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	913,000	195,125	487,454	1,595,579		1,595,579	(59,578)	1,536,001			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,609	4,609		4,609		4,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			22,611	22,611		22,611		22,611			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(49,868)	82,132			34
35	Rent-Equipment & Vehicles			13,741	13,741		13,741	(2,197)	11,544			35
36	Other (specify):*											36
37	TOTAL Ownership			172,961	172,961		172,961	(52,065)	120,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,501	34,501		34,501		34,501			42
43	Other (specify):* LAB/X-RAY			3,503	3,503		3,503		3,503			43
44	TOTAL Special Cost Centers			38,004	38,004		38,004		38,004			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	913,000	195,125	698,419	1,806,544		1,806,544	(111,643)	1,694,901			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(628)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(626)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,327)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(110,316)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (110,316)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (111,643)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		(24,131)	10-2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ (24,131)		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HEALTH SYSTEMS, INC.	100			N/A	N/A	MANAGEMENT CO
MED SUPPLY	100			N/A	N/A	MED SUPPLIES
STERLING HC INTERIOR	100			N/A	N/A	GEN SUPPLIES
SYSTEMS LEASING	100			N/A	N/A	LEASING CO
HSI BENEFIT SYSTEM, LLC	100			N/A	N/A	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	\$ 111,087	HEALTH SYSTEMS, INC.	100.00%	\$ 54,421	\$ (56,666)	1
2	V	34	MGT FEES-CAPITAL COST		HEALTH SYSTEMS, INC.	100.00%	18,601	18,601	2
3	V	10	MGT FEES-NSG CONS		HEALTH SYSTEMS, INC.	100.00%	346	346	3
4	V	10	NURSING SUPPLIES	29,431	MED SUPPLY	100.00%	23,015	(6,416)	4
5	V	22	EMP BENEFITS	46	MED SUPPLY	100.00%	36	(10)	5
6	V	10	NURSING SUPPLIES	661	STERLING HC INTERIOR	100.00%	836	175	6
7	V	1	DIETARY SUPPLIES	1,073	STERLING HC INTERIOR	100.00%	1,356	283	7
8	V	4	LAUNDRY SUPPLIES/SERV	11,367	STERLING HC INTERIOR	100.00%	14,370	3,003	8
9	V	3	HOUSEKEEPING SUP/SERV	7,230	STERLING HC INTERIOR	100.00%	9,140	1,910	9
10	V	6	PLANT	1,183	STERLING HC INTERIOR	100.00%	1,496	313	10
11	V	21	DECORATING	919	STERLING HC INTERIOR	100.00%	1,162	243	11
12	V	22	EMP BENEFITS	93	STERLING HC INTERIOR	100.00%	117	24	12
13	V	26	PROPERTY INSURANCE	7,869	HSI BENEFIT SYSTEM, LLC	100.00%	7,980	111	13
14	Total			\$ 170,959			\$ 132,876	\$ * (38,083)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	HEALTH INSURANCE	\$ 47,948	HSI BENEFIT SYSTEM, LLC	100.00%	\$ 48,629	\$ 681	15
16	V	10	NURSING SUPPLIES	486	SYSTEMS LEASING	100.00%	331	(155)	16
17	V	35	EQUIPMENT	6,892	SYSTEMS LEASING	100.00%	4,695	(2,197)	17
18	V	5	CABLE TV	3,085	SYSTEMS LEASING	100.00%	2,101	(984)	18
19	V	22	INSURANCE	3,478	SYSTEMS LEASING	100.00%	2,369	(1,109)	19
20	V	34	FACILITY LEASE	132,000	VIENNA-RE LLC	100.00%	63,531	(68,469)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 193,889			\$ 121,656	\$ * (72,233)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLVIEW HEALTH CARE CENTER # 0045302 Report Period Beginning: 1/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HILLVIEW HEALTH CARE CENTER # 0045302 Report Period Beginning: 1/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2	SEE HOME OFFICE COST REPORT								2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	NONE						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	NONE												6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	NONE												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	21,7461
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	22,6112
3. Under or (over) accrual (line 2 minus line 1).				\$	8653
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	21,7464
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	22,6117
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	16,325	8	
		2001	27,516	9	
		2002	20,107	10	
		2003	21,526	11	
		2004	22,611	12	
				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLVIEW HEALTH CARE CENTER COUNTY JOHNSON

FACILITY IDPH LICENSE NUMBER 0045302

CONTACT PERSON REGARDING THIS REPORT CARLA HEDRICK

TELEPHONE (573) 481-9625 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 08-05-201-008	S PT W PT N 1/2 SW NE QTR (5.25A	\$ 22,611.28	\$ 22,611.28
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 22,611.28	\$ 22,611.28

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

21,207

B. General Construction Type:

Exterior

CONCRETE BLOCK

Frame

WOOD

Number of Stories

1+BASEMENT

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	PATIO AWNING		2004		2,400	480		480		720
10	VINYL FLOORING		2005		10,739	1,074		1,074		1,074
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$13,139	\$1,554		\$1,554	\$	\$1,794	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 15,275	\$ 970	\$ 3,055	\$ 2,085	5	\$ 5,096	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 15,275	\$ 970	\$ 3,055	\$ 2,085		\$ 5,096	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 28,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,524	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,609	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,085	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,890	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: VIENNA RE, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	UNKNOWN	69	4/13/01	\$	20	10	3
4	Additions							4
5								5
6								6
7	TOTAL		69		\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☒ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 13,741
- Description: DW MACH \$659; COPIERS \$6,052; SOFTWARE \$2,640; MATTRESS \$2,311; MED EQUIP \$2,079
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

10. Effective dates of current rental agreement:
- Beginning
- Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	\$ 132,000
13.	12/31/2007	\$ 132,000
14.	12/31/2008	\$ 132,000

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10-3	hrs	\$		\$ 27,990	\$		\$ 27,990	1
2	Licensed Speech and Language Development Therapist	10-3	hrs			2,085			2,085	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs			43,005			43,005	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 73,080	\$		\$ 73,080	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (7,811)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	66,557		3
4	Supply Inventory (priced at)	2,609		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	307,598		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 368,953	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,139		15
16	Equipment, at Historical Cost	15,275		16
17	Accumulated Depreciation (book methods)	(6,890)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,524	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 390,477	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 74,827	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,277		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,323		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,022		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERCOMPANY	71,698		36
37	LEASE	11,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 245,147	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 345,147	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 45,330	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 390,477	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (101,673)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (101,673)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	147,003	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 147,003	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 45,330	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number HILLVIEW HEALTH CARE CENTER # 0045302 Report Period Beginning: 1/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,124,746	1
2	Discounts and Allowances for all Levels	(381,614)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,743,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,441	6
7	Oxygen	52,934	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 208,375	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6	13
14	Non-Patient Meals	628	14
15	Telephone, Television and Radio	1,032	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,666	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	109	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 109	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	265	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 265	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,953,547	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	432,855	31
32	Health Care	764,386	32
33	General Administration	398,338	33
	B. Capital Expense		
34	Ownership	172,961	34
	C. Ancillary Expense		
35	Special Cost Centers	3,503	35
36	Provider Participation Fee	34,501	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,806,544	40
41	Income before Income Taxes (line 30 minus line 40)**	147,003	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 147,003	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,800	2,120	\$ 34,771	\$ 16.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,234	2,279	37,103	16.28	3
4	Licensed Practical Nurses	12,105	12,688	146,134	11.52	4
5	CNAs & Orderlies	35,845	37,832	307,190	8.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,792	1,982	18,423	9.30	9
10	Activity Assistants					10
11	Social Service Workers	3,326	3,685	47,885	12.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,977	13,109	110,109	8.40	15
16	Dishwashers					16
17	Maintenance Workers	1,744	1,973	29,583	14.99	17
18	Housekeepers	7,178	7,519	53,713	7.14	18
19	Laundry	3,459	3,759	27,661	7.36	19
20	Administrator	1,795	2,075	54,180	26.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,772	1,945	26,310	13.53	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,746	2,003	19,938	9.95	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	86,773	92,969	\$ 913,000 *	\$ 9.82	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	104	\$ 4,326	1-3	35
36	Medical Director	88	4,950	9-3	36
37	Medical Records Consultant	41	1,771	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,408	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	26	1,715	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	355	\$ 16,170		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number	HILLVIEW HEALTH CARE CENTER
--------------------------------------	------------------------------------

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	%	Amount		Description		Amount		Description		Amount	
TAMMY SAMUALS		ADMINISTRATOR		\$	40,651	Workers' Compensation Insurance		\$	38,863	IDPH License Fee		\$	
CYNTHIA HALL		ADMINISTRATOR			13,529	Unemployment Compensation Insurance				Advertising: Employee Recruitment			434
						FICA Taxes			80,032	Health Care Worker Background Check (Indicate # of checks performed _____)			
						Employee Health Insurance			28,161	ADVERTISING-OTHER			576
						Employee Meals				DUES & SUBSCRIPTIONS			139
NOTE: INCLUDES V/H/S INCLUDED ON LINE 21						Illinois Municipal Retirement Fund (IMRF)*				TAXES & LICENSES			1,990
TOTAL (agree to Schedule V, line 17, col. 1)						R/P ADJUSTMENT			(414)				
(List each licensed administrator separately.)				\$	54,180								
B. Administrative - Other													
Description					Amount								
				\$									
TOTAL (agree to Schedule V, line 17, col. 3)				\$		TOTAL (agree to Schedule V, line 22, col.8)		\$	146,642	Less: Public Relations Expense			(50)
(Attach a copy of any management service agreement)										Non-allowable advertising			(576)
C. Professional Services										Yellow page advertising		(
Vendor/Payee		Type			Amount					TOTAL (agree to Sch. V, line 20, col. 8)		\$	2,513
HEALTH SYSTEMS, INC		ACTIVITY CONSULTING	\$		1,631	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
TALX		EMPLOYEE SCREENING			12,315	Description		Line #	Amount	Description		Amount	
BUESSINK, HEY & ROE		ACCOUNTING			880					Out-of-State Travel		\$	806
HEALTH SYSTEMS, INC		ACCOUNTING			5,100								
HEALTH SYSTEMS, INC		MANAGEMENT FEES			101,787					In-State Travel			498
										Seminar Expense			
										Entertainment Expense		(
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL				(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$2500 attach copy of invoices.)				\$	121,713			\$		TOTAL		\$	1,304

*** Attach copy of IMRF notifications**

****See instructions.**

(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

NO
- (3) Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$
Line

N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES
NO
IDPH license number of this related party and the date the present owners took over.

X
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$

34,501
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

NO
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
related costs?
Has any meal income been offset against related costs?
Indicate the amount.

\$

0

YES

\$

628
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

YES

ADMINISTRATOR MEETINGS IN MO

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

NONE

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO

\$

NONE
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

NO
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A